COMMUNICABLE DISEASES SCREENING

Name:_____ DATE:_____

1. Are you experiencing any of the following symptoms: Fever, Shortness of breath, cough, nasal congestion, runny nose, sore throat, nausea, vomiting and/or diarrhea?

   ____YES ____NO

2. Have you been in close contact with someone with confirmed novel Coronavirus (COVID – 19) in the past 14 days?

   ____YES ____NO

3. If YES to #1 or #2, do you have any symptoms that started in the past 14 days:

   _____ Fever at or higher than 100.4 degrees F or 38.0 degrees C

   _____ Cough

   _____ None of the Above

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS YOU MUST REPORT TO THE RECEPTIONIST.